

Enrollee and Provider Complaint/Appeal Reports

Instructions

- 1. The Monthly Summary Report must contain the following elements, and be in the format below:**

Month: _____

Date Received	Date Closed	Complainant	County	Complaint Type/Summary	Disposition	Age(days)
Date Received	Date Closed	Complainant Type. Use appropriate complainant codes below	County where complaint is originated	Complaint/Appeal Type Code (according to State code list). Identify complainant by NS ID (if enrollee), or by Organization Name, if complainant is Provider. Indicate Name of Entity that the complaint is against. Also provide a <u>Succinct</u> Summary of Nature of Complaint. (If claims related complaint/appeal, indicate approximate \$ amount involved)	Disposition Code (according State codes list). In addition to code, provide a Succinct summary of what was done to resolve.	Age of process, from Intake to Final Disposition

COMPLAINANT CODES

(H) Hospital

(MHI) MH Inpatient

(E) Enrollee

(OAG) Other Adv Group

(Fr) Friend

(CDI) CD Inpatient	(MHO) MH Outpatient	(B) BHO	(W) Witness	(O) Other
(CDO) CD Outpatient	(LIP) Lic. Ind. Practioner	(D) DANSA	(F) Family	

2. Recording Multiple Complaints:

- A. An Enrollee complaint regarding multiple issues (e.g., quality of care, access to treatment, and blance billing), should be recorded as separate complaints for each issue on the narrative summary report.**
- B. Multiple complaints received from the same Enrollee regarding the same issue (e.g.,provider attitude) by the same provider should be recorded as one complaint on the narrative summary report.**
- C. A provider complaint about multiple unpaid or underpaid claims denied or underpaid by Contractor, and were unpaid or underpaid for the same denial code (e.g timely submission), should be recorded as multiple complaint complaints on the narrative summary report.**
- D. A provider complaint about multiple unpaid or underpaid claims, some of which were denied for multiple reasons (e.g. non-authorization, some for incompleteness, and some for incorrect information) should be recorded as separate complaints on the narrative summary report.**

Complaint Codes:

(QC) Quality of Care or Service	
QC0 Other	any quality of care complaint that can't be categorized with another code
QC4 Diagnosis(untimely or missed)	Complaint addressing an inaccurate diagnosis, a partial diagnosis, or an untimely diagnosis given by provider
QC5a Treatment inappropriate, ineffective (provider)	Complaint is regarding the level of appropriateness of treatment administered. This could involve such instances where provider treatment was proven to be below medial standards, is ineffective because of a misdiagnosis, inappropriate administration of the treatment, or inappropriate methodology. Poor quality of treatment by provider

QC5b Not enough time with provider	Provider does not spend adequate time with client
QC5c Provider often no shows	Provider often cancels set appointments
QC5d Provider Doesn't Review Chart or Notes	Provider does not seem to review clinical documentation/appear knowledgeable of client circumstances prior to appt. or interaction
QC5e Frequency of Service Inadequate	Does not see provider at desired frequency
QS5 Service inappropriate or ineffective (BHO)	BHO does not provided good customer service; staff not helpful or knowledgeable
QC6a Medication error-Wrong Med Prescribed	medication prescribed by provider was incorrect
QC6b Wrong Dosage Prescribed	medication dosage prescribed by provider was not correct
QC6c Won't Prescribe Requested Medication	Client states certain medication is needed, and provider refuses to prescribe
QC6d Won't Prescribe Non-Formulary or Off Label	Provider will not prescribe medication that has off label benefit, or is not on formulary
QC6e On Wait List	DELETE (use UR5b)
QC6f Doesn't Prescribe Any Medication	Client states that medication is needed, and provider refuses to prescribe
QC7 Quality of provider credentialing	Provider generally seems unqualified for services performed
QC8 Quality of provider facility	Poor condition of facility (dirty, in disrepair, unsanitary, etc.)
QC9 Quality of goods/materials	Provider van is in poor condition
QC10 Ineffective communication	No call backs or poor directions/instructions given by provider
QC11 Quality of records	Provider recordkeeping is disorganized; file keeping system disorganization
QC14 ADA Non-compliance	Provider is non-compliant with ADA requirements
QC15p Provider attitude inappropriate	Provider rude, obnoxious, inappropriate
QC15cs BHO customer service attitude inappropriate	BHO customer service staff rude, obnoxious, inappropriate
QC15cm Care Management attitude inappropriate	BHO care management staff rude, obnoxious, inappropriate
QC16 Provider abuse or neglect	Provider abuse, neglect, exploitation as defined by PRS
QS16 BHO Unresponsiveness	BHO unresponsive to customer or provider inquiry; poor instructions given
(AC) Accessibility/Availability	
AC0 Other	any access related complaint that can't be categorized with another code
AC1 In-Network Provider Access	can't access in network provider (provider not accepting more patients)
AC2 Provider selection or turnover	Provider left network, citing problems with BHO/managed care
AC4 Out -of-network Provider access	service is not available in network but cannot see out of network provider
AC7 Continuity of Treatment	no aftercare appt given after discharge from State or community hospital. No step down level of care offered

AC8 Emergency care access	provider will not provide emergency care
AC9 Delay of referral/authorization	provider delays/refuses to facilitate transition to another provider
AC10 Delay of Necessary Treatment	Treatment is delayed by provider (ex. Supposed to begin rehab, but there's a delay due to staff problems)
AC11 Benefits access inadequate	Cannot receive benefits due to computer problems not recognizing client
AC12 Inability to access treatment	distance too far to get to provider
A complaint regarding the Civil Rights Act. Such a complaint would include discriminatory denial of services based on race, age, religion, sex, political beliefs, color, or national origin. This complaint can also concern patterns of discriminatory behavior singling out a specific group, or no provision or ineffective provision of services. Also, preventing a person from leaving a facility.	
AC13 Civil Rights non-compliance	
AC14 24 hr. cvrg provider accessibility	Cannot reach ValueOptions by Telephone
AC15 Urgent care accessibility	Mobile crisis service unresponsive
AC16 Appointment availability	Can't get an appointment in a timely manner
AC17 Telephone wait time for inquiries	Put on hold excessively or for an excessive period of time
AC18 Wait time in provider's office	Wait time in waiting room excessive
(UR) Utilization Review / Mgt	
UR0 Other	any Utilization Review related complaint that can't be categorized with another code
UR3 Denial/Non pymt-Treatment-non-ER Service	VO will not authorize routine care
UR3a UR3 Denial/Non pymt-Treatment (Denial of Disease Mgt. Service Package)	VO will not authorize requested RDM service package or parts of package
UR4 Denial/Non payment-Supplies	N/A
UR5a Denial/Nonpayment-Non-Formulary Medication	VO will not authorize requested medication that was not on NorthSTAR formulary
UR5b Denial/Nonpayment-Wait List Medication	VO will not authorize medication, stating that there is a waiting list
UR5c Denial/Nonpayment-Medicaid Enrollee with Prescription not covered by Vendor Drug	VO will not authorize a medication for a Medicaid enrollee that is not covered by Vendor Drug (Medicaid)
UR5d Denial/Nonpayment-Administrative Reasons (Pre-Cert Problems, Fax Problems, Dosage Override, NS # not Recognized, etc.	Authorization not given due to Pre-Cert Problems, Fax Problems, Dosage Override, NS # not Recognized, Incorrect diagnosis, etc.

	A complaint regarding the member's discharge or admission to an inappropriate facility. Example: Patient was discharged from hospital to go home, instead of to a nursing home.
UR6 Hospital Admission/Discharge	
UR7 Continuation of services/Hospital	VO will not authorize continued stay in hospital
UR8 Denial of authorization of care	VO will not authorize care for requested level of service
UR9 Pre-authorization issues	Pre-authorization process is overly time-consuming or burdensome
(CP) Complaint Procedure	
CP0 Other	Complaint Procedure related complaint that can't be categorized with another code
	Complaint resolution process is inadequate in its ability to address the grievance, it is unnecessarily lengthy, extremely difficult to follow, or discourages clients from filing complaints.
CP1 BHO complaint procedure	Complaint regarding a MCO's appeals process; MCO is not following the proper steps in an appeal process.
CP2 BHO appeal process	
	Complaint is regarding a MCO's telephone access; it is inadequate and/or inaccessible. Example: Telephone line is always busy.
CP3 Telephone access (to BHO)	
(PC) BHO Contract w/ Provider	
PC0 Other	Provider contract related complaint that can't be categorized with another code
	BHO has unreasonable requirements for contracting; BHO's contract with provider has not been followed; credentialing problems preventing provider getting into network
PC1 BHO pre-conditions for contract	Physicians' financial incentives are inhibiting the number of referrals provided and the treatment provided to patients. Example: Member feels physician in MCO has financial incentives to keep cost low and it has negatively affected the quality of care, access to care, and so forth received.
PC2 Financial incentives	
PC3a Denial, delay of payment	Non-payment of claim for reason not related to authorization (timely, member ineligible, etc)
PC3a Denial, delay of payment	Non-payment of claim for reason related to pre-authorization
PC4 Reimbursements or capitation	Rate paid was incorrect
	A complaint by the provider of a material loss or harm caused by the MCO, such as payment withholding, threat of, defamation of, or restriction of professional standing or practice, or other MCO measures that cause direct harm to the provider.
PC5 BHO retaliation	

PC7 Tort liability shift to provider	A complaint by the provider that the MCO is holding the provider solely liable for a responsibility that is either solely a MCO or a shared MCO/provider responsibility.
PC8 Distribution of enrollees	A complaint regarding the assignment of no more than 1,500 members across all participating managed care plans in the Service Area.
PC9 STP participation	A complaint regarding the MCO not making a good faith effort to seek participation from each significant traditional provider in the Service Area. A MCO is required to include in its provider network for not less than three years after implementation of Medicaid managed care in a Service Area, all significant traditional providers.
PC10 Physician requested disenrollment	A complaint by the member, regarding the request from their PCP for their disenrollment. A PCP may request that a member be reassigned to a different PCP because of a pattern of member noncompliance with Medical advice or office decorum.
(MC) BHO Contract with State	
MC0 Other	BHO contract related complaint that can't be categorized with another code
MC2 Material change made in contract	MCO's complaints regarding material that was changed in their contract with the State agency without their knowledge.
MC3 BHO to BHO communications	Complaint is regarding the lack of coordination between MCO's. As managed care evolves, more and more MCO's are working together to provide services. They have to communicate effectively to be able to provide the best possible care.
MC4 BHO requested disenrollment	N/A
MC5 Medicaid ID card issues	N/A
(EC) BHO Obligation to Enrollees	
EC0 Other	enrollment related complaint that can't be categorized with another code
EC5 Denial/Nonpayment for ER care	N/A
EC6 Claims reimbursement/balance billing	Balance billing by provider to enrollee
EC8 BHO retaliation	Member complains of denial of benefits, loss of MCO coverage, defamation of character, or MCO disclosure of member confidential information because of the member's concern that the MCO is retaliating or harassing the member.

EC9 Confidentiality of medical info	A complaint by the member that the MCO released unauthorized confidential medical information. The complaint is regarding the unauthorized disclosure of certain confidential medical information such as diagnosis, evaluation, and or treatment. (Note: The Member must give written consent for release of any pertinent information before any client information can be released. The provider is not required to receive permission when the release is requested by and or made to TDHS, TDH, NHIC, PRS, HHSC, Office of Investigations and Enforcement, the Texas Attorney General's Medicaid Fraud Control Unit, or HHS.)
EC10 Experimental/investigation proced.	A complaint by the member that the provider is suspected of or is using experimental or investigatory medical procedures on the patient
EC11 Enrollment,reenrollment, cancellation	enrollment problems, re-enrollment problems or disenrollment problems
EC12 Incorrect enrollee information	N/A
EC13 Cultural Competency	A complaint regarding the inability of individuals and or systems to provide services effectively to people of all cultures, races, ethnic backgrounds and religions, in a manner that affirms the worth and protects the dignity of individuals, families, and communities. Examples: MCO is not providing translated written materials to members. MCO is not providing interpreters for orientations or health education activities. Providers are not calling for interpreters, or demonstrate a lack of understanding around specific policies or procedures on the provision of interpreters.
(MK) Marketing	
MK0 Other	Marketing related complaint that can't be categorized with another code
MK3 Marketing ethics violations	Complaint regarding the MCO's publications and or tactics . MCO may not be following the guidelines set forth by the State agency; therefore, marketing unethically. Example: A MCO signs up an individual to a policy without their knowledge
MK4 Marketing guidelines violations	MCO complains about the State agency's marketing guidelines; MCO may feel that the guidelines are too harsh and or unfair.
(MS) Miscellaneous Complaints	
MSO Other	Miscellaneous complaint that can't be categorized with another code